

New Pain Patient Intake Form

Dear Patient,

Please complete this form **before** arriving at our office. This will help our physicians and staff ensure that you have a smooth and timely visit. In order to best serve you, we must learn as much as we can about you and your painful condition. It is *imperative* that you take the time to complete this questionnaire **before** you come for your first visit. The information that you include is vital to your treatment. It will be reviewed by your physician become a permanent part of your chart in our practice.

Referring physician: Name: _____
Address: _____
City: _____
State: _____
Phone#: _____

Family physician: Name: _____
Address : _____
City: _____
State: _____
Phone#: _____

Other physicians that you have seen for this problem:

Name: _____
Address: _____
City: _____
State: _____
Phone#: _____

Name: _____
Address: _____
City: _____
State: _____
Phone#: _____

Which pharmacy will you be using?

Name: _____
City: _____
Phone #: _____



Patient Name: _____

PAIN HISTORY

What pain complaint are you here for? _____

When did your pain start (month and year) _____

Was your pain of: sudden onset gradual onset

Did your pain originate from?

Auto accident Fall or slip After Surgery Nothing in particular Work accident
 Home injury Other _____

What time of day is your pain worse?

Morning upon waking Later in the morning
 Afternoon Evening
 Bedtime Night (after going to sleep)
 Pain is always the same Other _____

Describe your pain

throbbing sharp tingling buzzing scalding
 dull aching hot cold pulsing
 shooting radiating tight burning stabbing

What makes your pain worse (please be specific)?

What lessens or relieves your pain (please be specific)?

Have you ever had any of the following procedures?

MRI Head Neck Spine Stress Test Open heart surgery
 CT scan Head Neck Spine Catherization Angioplasty / stent placement
 X-rays Head Neck Spine Myelogram Bone Scan EMG

Where did you have your imaging done? _____

Have you had: Physical therapy Injections TENS unit Chiropractic

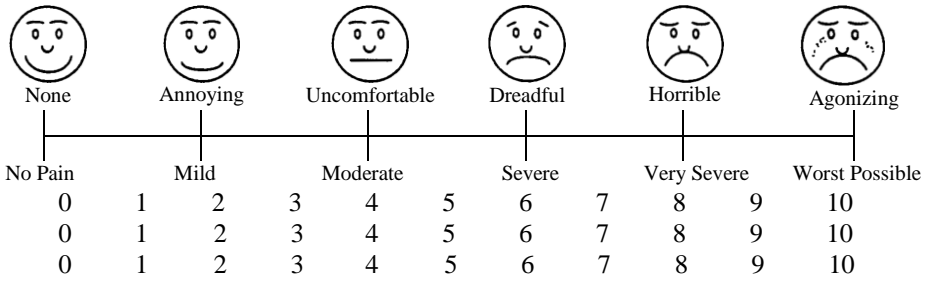
Do you have any problems with:

bowel or bladder control
 Muscle weakness
 Numbness
 Sleeping less than 6-8 hrs/night

Which statement best describes your pain pattern: (check one)

Pain is always present and is always the same intensity
 Pain is always present and the intensity varies
 Pain is usually present but I have short periods without pain
 Pain is occasionally present. I only have pain a couple of times a day
 Pain is rarely present. I have pain every few days or weeks

Pain Scale

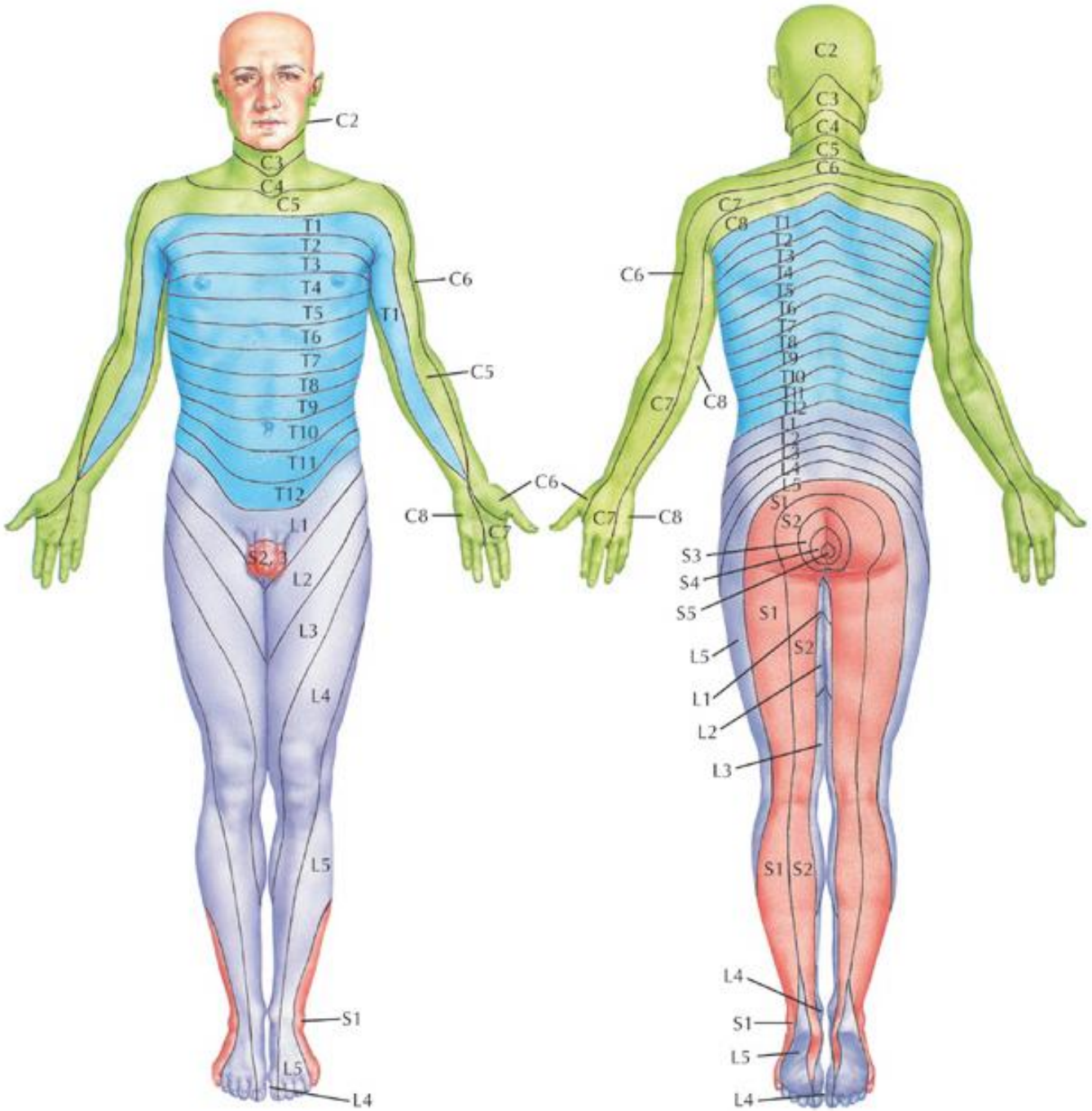


Circle your level of pain today:

What level of pain can you function with?

What is an acceptable level of pain for you?

Pain diagram- Draw or shade in the areas where you are experiencing pain



REVIEW OF SYSTEMS—Are you currently, or have you ever had problems with the following:

Constitutional

Fever Yes No
 Weight Loss Yes No
 Excessive Fatigue Yes No
 Night Sweats Yes No
 Eye Infections Yes No
 Eye Injuries Yes No
 Glaucoma Yes No
 Cataracts Yes No
 Wear Glasses Yes No

Ear, Nose, Throat, & Mouth

Balance Disturbance (vertigo/spinning) Yes No
 Sore Throats Yes No
 Mouth Sores Yes No
 Nosebleeds Yes No
 Nasal Congestion Yes No
 Inability to smell Yes No
 Sinus Problems Yes No
 Sinus Headaches Yes No
 Nasal Drainage Yes No
 If yes, color _____ amount _____
 Wear a Hearing Aid Yes No
 If yes, date of last exam _____
 Ringing in Ears Yes No
 If yes, indicate left, right, or both _____
 Hearing Loss Yes No
 Ear Pain Yes No
 Ear Infections Yes No

Cardiovascular

Swelling in feet or hands Yes No
 High Blood Pressure Yes No
 Irregular Pulse Yes No
 Heart Murmur Yes No
 High Cholesterol Yes No
 Chest Pain or Angina Yes No

Respiratory

Asthma Yes No
 Chronic cough Yes No
 Emphysema Yes No
 Bronchitis Yes No
 Pneumonia Yes No
 Shortness of breath Yes No
 Lung cancer Yes No
 Bloody sputum Yes No
 If yes, date of last chest x-ray _____

Gastrointestinal

Indigestion or pain with eating Yes No
 Nausea Yes No
 Vomiting Yes No
 Liver Disease Yes No
 Abdominal pain Yes No
 Change in your bowel habits Yes No
 Ulcers or Gastritis Yes No
 Colon Cancer Yes No

Genitourinary

Urinary tract infections Yes No
 Painful urination Yes No
 Blood in urine Yes No
 Difficulty starting/stopping stream Yes No
 Incontinence Yes No
 Kidney stones Yes No
 Prostate cancer (males) Yes No
 Endometriosis (females) Yes No
 Uterine or Cervical cancer (females) Yes No

Musculoskeletal

Arm or leg weakness Yes No
 Arm or leg pain Yes No
 Back pain Yes No
 Joint pain or swelling Yes No
 Arthritis Yes No
 Broken bones (list) _____ Yes No

Integumentary

Skin disease Yes No
 Skin cancer Yes No

Neurological

Fainting spells Yes No
 Seizures Yes No
 Problems with memory Yes No
 Disorientation Yes No
 Difficulty with speech Yes No
 Inability to concentrate Yes No
 Double or blurred vision Yes No
 Face weakness Yes No
 Lack of coordination in arms or legs Yes No
 Leg pain while walking Yes No

Psychiatric

Anxiety Yes No
 Depression Yes No
 Other psychiatric disorders/treatment _____

Endocrine

Diabetes Yes No
 Thyroid disease Yes No
 Excessive thirst or urination Yes No
 Hormone problems Yes No

Hematologic/Lymphatic

Anemia Yes No
 Hemophilia Yes No
 Bleeding tendencies Yes No
 Persistent swollen glands/lymph nodes Yes No
 Blood transfusion Yes No
 If yes, when _____

Immunologic

Immunologic disorders Yes No

Patient Name: _____

MEDICAL HISTORY

Allergies: _____

PAST MEDICAL HISTORY

Heart disease (heart attack)		Migraines	
Congestive heart failure		Arthritis	
Stroke		Stomach Ulcers or GERD	
High blood pressure		Diabetes I or II	
Kidney disease		Asthma	
Lung Disease		Anemia	
Cancer		Seizures	
Skin disease		Sickle cell disease	
Thyroid disease		HIV/ AIDS	
Liver disease (hepatitis)		Mental Illness	

Please explain anything that you checked

Do you take: blood thinners coumadin daily aspirin plavix trental

Please list **all** of the drugs, you are taking or have taken for your pain condition and indicate how effective these drugs were.

MEDICATION

EFFECTIVENESS

CHECK IF STILL TAKING

	<i>Not at all</i>					<i>Very effective</i>					
	1	2	3	4	5	1	2	3	4	5	_____
_____											_____
_____											_____
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_____											_____

FAMILY HISTORY

Please list all that apply to your family (mother, father, brothers, sisters, or your children)

- | | | | |
|---|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Alcoholism | |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Other _____ | | |

PAST SURGERIES

SURGERIES/ HOSPITALIZATIONS	YEAR	PHYSICIAN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

SOCIAL HISTORY

Family/ support group *Single* *Married* *Widow* *Divorced*

Number of Children? _____

Do live alone? *yes* *no*

Do you use alcohol? *yes* *no*
If yes...how often *daily* *weekly* *socially*

Do you smoke? *yes* *no* _____ *packs/day* *How many years?* _____ *Quit* _____

Do you use recreational drugs? *Yes* *no*
If yes...which ones *marijuana* *cocaine* *crack* *amphetamines* *other* _____

Have you every had a problem with alcohol or drug abuse? *yes* *no*

Are at risk for HIV/ AIDS? (IV drug abuse, sexual orientation, previous blood transfusion) *yes* *no*
If yes please explain. _____

Are you currently working *yes* *no* *retired* *off work because of the pain*

What is the highest level of education that you have? _____

Where do you work? _____

Describe your duties at work. _____

Is there any special information we should know about you that has not already been covered?
 (examples: do you have a pacemaker, metal implants, rare blood disorder, Jehovah's Witness, etc.)

The information is accurate to the best of my knowledge.

 Patient Signature

I have reviewed the above information.

 Physician Signature



Patient Name: _____